



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Jose Monsivais, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-11-3027

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claimant was requested to have a DESIGNATED DOCTORS EVALUATION per the TDI-DWC... This appointment was not cancelled nor were we informed that this claim was not an accepted workers compensation claim, thus exam was billed per the TDI Rule 133.240 (a) and to be reimbursed at 100% of the billed charges with out reductions being taken..."

Amount in Dispute: \$1165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... The requestor is a participating doctor in the Texas Star Network... Texas Mutual claim ... is in the same Network..."

DWC Rule 180.21(a)(2)(F) states in part, 'Any association that may reasonably be perceived as having potential to influence the conduct or decision of a doctor, which may include... a contract with the same workers' compensation health care network that is responsible for the provision of medical benefits to the injured employee...'

DWC has not provided any waivers or exceptions to this proscription. Therefore, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2011	Designated Doctor Examination Work Status Report	\$1165.00	\$1150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.6, effective January 1, 2007, 33 TexReg 6368, sets out the procedures for Designated Doctor examinations for maximum medical improvement and impairment ratings.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 364, addresses medical reimbursement for this date of service.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, 33 TexReg 364, sets out the fee guidelines for billing and reimbursement of division-specific services.
5. Texas Labor Code §408.0041, effective September 1, 2007, provides guidance for designated doctor examinations.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-W1 – Workers compensation state fee schedule adjustment
 - 788 – Texas Star Network Dr. may not perform DD exams for workers receiving care through same network per Chapter 126 &/or 127 and Rule 180.21.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724 – No additional payment after a reconsideration of services.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The dispute involves reimbursement of fees for a designated doctor examination. The insurance carrier denied payment because the designated doctor was contracted with the same network under which the injured employee's claim is administered, using claim adjustment code 788 – "TEXAS STAR NETWORK DR. MAY NOT PERFORM DD EXAMS FOR WORKERS RECEIVING CARE THROUGH SAME NETWORK PER CHAPTER 126 &/OR 127 AND RULE 180.21."

28 Texas Administrative Code §134.1 states,

- (b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, **except as provided in subsections (c) [emphasis added] and (d) of this section.**
- (c) Examinations conducted pursuant to Labor Code §§408.004, **408.0041 [emphasis added]**, and 408.151 **shall be reimbursed in accordance with §134.204 [emphasis added]** of this chapter...

Texas Labor Code §408.0041, effective September 1, 2007, provides the authority of the Commissioner of the Division of Workers' Compensation to order a designated doctor examination. Further, subsection (h) of this statute states, "The insurance carrier shall pay for: (1) an examination required under Subsection (a)."

Review of the submitted documentation finds that the requestor was ordered to perform the designated doctor examination in question via EES-14 dated December 8, 2010. Therefore, the disputed services were provided pursuant to Texas Labor Code §408.0041(a). The insurance carrier's reason for denial of payment is not supported and shall be reviewed according to 28 Texas Administrative Code §134.204.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical

evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area.” The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right upper extremity. Therefore, the correct MAR for this examination is \$300.00.

Per 28 Texas Administrative Code §134.204 (k),

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier “RE.” In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is \$500.00.

Per 28 Texas Administrative Code §134.204(l), “The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)”. Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i).

3. The total MAR for the disputed services is \$1150.00. The insurance carrier paid \$0.00. A reimbursement of \$1150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	January 22, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision*, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.